

The University of Toledo
Department of Counseling and Mental Health Services

Supervisor Qualification Form

Name:			
Title:			
Business Address:			
Phone:		2 nd Phone:	
Fax:		Email:	
Scope or type of activities provided:			

Licenses:

License	State and/or Agency Awarding License	License Number	Date Awarded

Certifications:

Certification	State and/or Agency Awarding Certificate	Certificate Number	Date Awarded

Degrees (most recent first):

Degree	College or University	Program of Study	Date Awarded

Work Experience (most recent first):

Title	Agency or Institution	Starting Date	Ending Date

Other Relevant Training:

Date: _____

Signature _____

Please return this form to:

Internship Faculty Supervisor
Department of Counseling and Mental Health Services
Mail Stop 119
The University of Toledo
2801 W. Bancroft St.
Toledo, OH 43606